

Executive Action Against AIDS: A Proposal for Federal Regulation Under Existing Law

GILBERT GAYNOR*

I. INTRODUCTION

AIDS knows no state boundaries. Various regulatory measures addressing Acquired Immune Deficiency Syndrome (AIDS) have been promulgated by state and local authorities,¹ but no inclusive nationwide minimum standards exist which assure confidentiality for persons wishing to be tested for the human immunodeficiency virus (HIV), or which guarantee non-discrimination against both persons with AIDS and those testing positive for the HIV antibody.

Within the past year, two national bodies have completed in-depth studies of the AIDS epidemic. The 1988 joint report of the National Academy of Sciences and the Institute of Medicine has proposed a new federal statute specifically designed to prevent HIV-related discrimination.² The Presidential Commission on the Human Immunodeficiency Virus Epidemic has proposed that Congress amend section 504 of the Rehabilitation Act of 1973—which prohibits discrimination on the basis of handicap, including contagious disease, by the federal government and by the recipients of federal funds³—to cover the private as well as the public sector,⁴ and has proposed the enactment of federal confidentiality legislation.⁵ The call for a federal legislative response has also been heard in the law reviews⁶ and in medical journals.⁷

* Member of the California Bar; LL.M. candidate, Harvard Law School 1988-89. Susan McGreivy, Mary Ellen Gale, Tarik Adlai, and Mary Anne Bobinski helped make this Article a reality.

1. A special assistant to President Reagan, Dr. Donald MacDonald, has stated that 36 states have passed laws that protect individuals against AIDS discrimination. *Reagan Proposal Responding to Report Excludes Anti-Discrimination Support*, 3 AIDS POL'Y & LAW, (BNA) No. 15, at 12 (Aug. 10, 1988). However, there appears to be no current compilation of all AIDS-related legislation, or of all such legislation related to the issues of discrimination and confidentiality. Assuming Dr. MacDonald's statement is accurate, 14 states have no legislation protecting AIDS victims from discrimination. As Professor Arthur S. Leonard states elsewhere in this issue, there are "large gaps in coverage" of laws prohibiting AIDS-related employment discrimination. Leonard, *AIDS, Employment and Unemployment*, 49 OHIO ST. L.J. 929, 941 (1989).

2. INSTITUTE OF MEDICINE/NAT'L ACADEMY OF SCIENCES, *CONFRONTING AIDS: UPDATE 1988*, at 64 (1988).

3. *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987); see *Chalk v. United States Dist. Court Cent. Dist. of Cal.*, 840 F.2d 701 (9th Cir. 1988). Section 504 of the Rehabilitation Act of 1973 is codified at 29 U.S.C. § 794 (1982). In March 1988, Congress overrode the President's veto of the Civil Rights Restoration Act of 1987, and essentially codified the Supreme Court's *Arline* decision that persons with contagious diseases are protected under the Rehabilitation Act. 29 U.S.C. § 706(8)(C) (1982 and Supp. 1988).

4. REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 123 (June 24, 1988) [hereinafter REPORT OF THE PRESIDENTIAL COMM'N].

5. *Id.* at 127.

6. See Leonard, *AIDS, Employment and Unemployment*, 49 OHIO ST. L.J. 929, 941 (1989) ("a national legislative solution [to the problem of AIDS-related discrimination] is needed to compensate for the gaps in state and local law."); Banks and McFadden, *Rush to Judgment: HIV Test Reliability and Screening*, 23 TULSA L.J. 1, 34 (1987) ("Expanded testing cannot be carried out responsibly until state and federal authorities enact laws which better protect the civil and confidentiality rights of infected individuals.").

7. See Blendon & Donelan, *Discrimination Against People with AIDS*, NEW ENG. J. MED., Oct. 13, 1988, at 1026 ("[N]ew [federal] legislation [prohibiting AIDS-related discrimination] may be the only way of creating a climate of safety for people who are infected with HIV or at risk for infection.").

In October 1988, a concerted effort to enact federal legislation aimed at assuring confidentiality for HIV testees failed in the United States Congress.⁸

The proponents of the various national legislative solutions have assumed, without discussion, that no statutory authority exists which allows adequate scope for meaningful action by federal officials to guarantee prospective testees of the confidentiality of HIV test results and to protect infected individuals against HIV-related discrimination.

That assumption is incorrect. Under present law, an officer of the executive branch—the Secretary of Health and Human Services—has the clear authority to promulgate comprehensive public health regulations aimed at combating AIDS. This statutory authority has gone virtually unremarked in the recent scholarship on AIDS and the law.⁹

A set of administrative regulations issued by the Secretary of Health and Human Services under present statutes could operate to (1) encourage widespread voluntary testing for the HIV virus by assuring confidentiality and anonymity; (2) mandate nondiscrimination in employment by virtually all employers whose activities affect interstate commerce; (3) assure that health care providers who are recipients of federal funds will offer voluntary testing and counseling to all patients, and will not participate in any mandatory HIV testing programs; and (4) impose significant federal criminal penalties for violations of the regulations.

This Article sets forth the Congressional grant of authority to the Secretary to deal with communicable diseases. In order to illustrate the scope of present authority, this Article posits a hypothetical set of draft regulations designed to combat AIDS. The Article considers various possible legal challenges to the proposed regulations—arguments that the regulations would exceed statutory authority, contravene Congressional intent expressed in other statutes, violate due process guarantees, transgress principles of federalism, fail to preempt conflicting state laws, and run afoul of the commerce clause—and demonstrates why they should be rejected. The Article concludes with observations on the role of regulation in AIDS policy.

8. In 1988, in the final session of the 100th Congress, the House of Representatives passed H.R. 4757, the AIDS Counseling and Testing Act of 1988. Although it included protections for confidentiality substantively similar to those proposed in this Article, it did not include antidiscrimination guarantees. The Senate previously passed S. 1220, the Acquired Immunodeficiency Syndrome Research and Information Act of 1987, which included no such protections.

On October 13, 1988, "[t]he House and Senate . . . stripped [the] . . . bill of provisions guaranteeing confidentiality of AIDS test results and one billion dollars to expand counseling and testing for the epidemic disease over three years." Robinson, *Congress OK's Stripped-Down AIDS Package*, Boston Globe, Oct. 14, 1988, at 3, col. 2. Accord Molotsky, *Congress Passes Compromise AIDS Bill*, N.Y. Times, Oct. 14, 1988, at A12. The principal supporter of the House bill, Representative Henry A. Waxman, stated he was "bitterly disappointed" at the failure of the Congress to pass confidentiality legislation, but expressed optimism that a confidentiality statute would be passed "in the next year or two." *Id.*

9. The scholarship on AIDS which has recognized the existence of 42 U.S.C. § 264 has done so in connection with discussion of the potential for an administration to impose quarantines upon AIDS victims. See Gray, *The Parameters of Mandatory Public Health Measures and the AIDS Epidemic*, 20 SUFFOLK U.L. REV. 505, 521 (1986); Banks and McFadden, *supra* note 6, at 22.

II. THE SCOPE OF EXISTING FEDERAL AUTHORITY

"Congress has granted broad, flexible powers to federal health authorities who must use their judgment in attempting to protect the public against the spread of communicable disease."¹⁰ This plain statement, appearing in a 1977 federal district court decision upholding the prohibition of the sale and distribution of certain turtles likely to harbor disease-causing organisms, accurately summarizes the breadth and scope of regulations of communicable diseases authorized under present law.

42 U.S.C. section 264¹¹ empowers the Surgeon General with authority to make regulations to aid in the control of communicable diseases. It specifies in part:

*(a) The Surgeon General, with the approval of the Secretary, is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession . . .*¹²

On its face, the first sentence of section 264 would appear to give the Surgeon General literally unlimited powers to deal with communicable diseases. Regulations promulgated under these broad powers are enforceable through a powerful sanction: federal criminal law.

42 U.S.C. section 271(a)¹³ specifies: "Any person who violates any regulation prescribed under section . . . 264 . . . of this title . . . shall be punished by a fine of not more than \$1,000 or by imprisonment for not more than one year, or both."¹⁴

The authority to make regulations under section 264 is no longer vested in the Surgeon General. In 1966 Congress enacted an executive branch reorganization plan. It provided in part that "all functions" of the Surgeon General were "hereby transferred to the Secretary of Health, Education and Welfare."¹⁵ The Secretary of Health and Human Services is the statutory successor to that official. Thus, section 264 should be read as if the words "Secretary of Health and Human Services" replaced the words "Surgeon General."¹⁶ The substantive scope of the statute is unaffected.

Federal statutes are to be given their plain meaning.¹⁷

10. *State v. Matthews*, 427 F. Supp. 174, 176 (E.D. La. 1977).

11. 42 U.S.C. § 264 (1982).

12. *Id.* § 264(a) (1982) (emphasis added).

13. *Id.* § 271(a) (1982).

14. *Id.*

15. The relevant language is as follows:

[T]here are hereby transferred to the Secretary of Health, Education and Welfare (hereinafter referred to as the Secretary) all functions of the Public Health Service, of the Surgeon General of the Public Health Service, and of all other officers and employees of the Public Health Service, and all functions of all agencies of or in the Public Health Service.

Reorganization Plan No. 3 of 1966, 31 Fed. Reg. 8855, 80 Stat. 1610, reprinted in 42 U.S.C. § 202 at 47-48 (1982).

16. The clause "with the approval of the Secretary" in 42 U.S.C. § 264 is now meaningless surplusage.

17. *Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108-09 (1980).

The plain meaning standard is a venerable doctrine which continues to be routinely applied by the Supreme Court. See, e.g., *McLaughlin v. Richland Shoe Co.*, 108 S. Ct. 1677, 1681 (1988) (applying "plain language" standard to reading of the Fair Labor Standards Act); *International Paper Co. v. Ouellette*, 107 S. Ct. 805, 812 (1987) ("We resort to legislative materials only where the congressional mandate is unclear on its face." (quoting *City of Rome v. United States*, 446 U.S. 156, 199 (1980) (Powell, J., dissenting))).

III. PROPOSED REGULATIONS

A small universe of regulations authorized under section 264 and aimed at preventing AIDS might easily be imagined. Federal regulations could conceivably address such matters as sterile needle distribution, standards for the manufacture of condoms, hospice care of persons infected with the HIV virus, or the special needs of infected infants and children. This Article, however, does not purport to explore more than one critical sector of that universe, relating primarily to discrimination and confidentiality. Moreover, no claim is made that the regulations hypothesized in the following pages are the only possible regulations which might be made to address the issues of confidentiality or discrimination, or even that the proposed regulations are in their particulars superior to all other regulations which could be drafted to serve the same general purposes. Rather, the hypothesized regulations are offered to illustrate what can be accomplished to combat the spread of AIDS within the present statutory framework, and to define the parameters of federal regulation in this area.

As a preliminary matter, one might ask why federal action assuring confidentiality and nondiscrimination is considered desirable. The specific public health rationales for such measures are discussed in connection with questions of federalism.¹⁸ However, three considerations which undoubtedly moved both the Presidential Commission and the joint committee of the Institute of Medicine and the National Academy of Sciences to their independent recommendations of federal action are briefly touched on here, to supply a context for the proposed regulations and discussion to follow.

The first relates to the economic impact of AIDS.

Though the evidence is far from precise, the best estimate now available is that there are now between 1 and 1.5 million HIV-infected persons in the United States.¹⁹ Tragically, almost all infected persons will eventually develop AIDS: the Centers for Disease Control (CDC) projects that ninety-nine percent of HIV-positive individuals will develop AIDS, with a mean incubation period of 7.8 years.²⁰

"The average lifetime medical expenses (from diagnosis to death) per AIDS patient are estimated to be between \$65,000 and \$80,000."²¹ Thus, assuming the lower figures for both infection and patient care, the direct medical costs incurred in caring for AIDS patients in the foreseeable future will be \$65 billion.

Moreover, the indirect costs of the epidemic are also significant.

Indirect costs of the disease include the loss of wages because of illness and the loss of future earnings (which is great because AIDS kills young adults in their most productive years). More recently, indirect costs have been estimated at \$7 billion for the prevalent cases in 1986. Projections of the spread of the disease give rise to estimated expenditures totaling \$66.5 billion for that year, of which \$55.6 billion would be indirect costs.²²

18. See *infra* notes 40-59 and accompanying text.

19. REPORT OF THE PRESIDENTIAL COMM'N, *supra* note 4, at 3; accord CONFRONTING AIDS: UPDATE 1988, *supra* note 2, at 4.

20. Lui, Darrow & Rutherford, *A Model-Based Estimate of the Mean Incubation Period for AIDS in Homosexual Men*, 240 SCIENCE 1333, 1334 (1988).

21. CONFRONTING AIDS: UPDATE 1988, *supra* note 2, at 16.

22. *Id.*

Plainly, AIDS has an economic impact which is national in scope.

The second, interrelated consideration concerns a basic human motivation: fear. One recent example suggests the extent of this problem.

In the hope of arriving at a more precise figure [of the number of HIV-positive individuals in the United States], the CDC wanted to perform HIV tests on blood from 50,000 randomly selected Americans, but when 2,250 people were asked whether they would participate in such a study, 31 percent refused, despite assurances of privacy. Presumably people did not want to know the results of such a test, or *feared that the results would not remain private*.²³

The third consideration concerns our national commitment to the eradication of irrational discrimination. The humane treatment of HIV-infected persons and persons with AIDS is an end in itself. The Report of the Presidential Commission states the case simply and eloquently: "[E]ach act of discrimination, whether publicized or not, diminishes our society's adherence to the principles of justice and equality."²⁴

A. *Proposed Regulations Governing Anonymity and Confidentiality*

Proposed regulations seeking to encourage widespread voluntary testing for HIV made pursuant to 42 U.S.C. section 264 might provide the following:

1. All sexually transmitted disease clinics, drug abuse treatment centers, hospitals, medical clinics, and medical offices receiving any federal funds, including Medicare and Medicaid funds, in excess of \$30,000 in the 1988 fiscal year shall:

A. Offer testing and counseling for AIDS to all persons wishing to be tested, at a fee which shall not exceed the rate for comparable blood tests charged by the hospital, clinic, or office at the time of implementation of this regulation;²⁵

B. Inform all persons receiving either out-patient or in-patient care at such federally-funded facilities in writing of the availability of testing and counseling for AIDS at the facility, the cost of such testing, and the provisions of these regulations relating to anonymity, confidentiality, and nondiscrimination;

C. Offer out-patient testing and counseling on an anonymous basis to all persons, identifying testees only through a number not related to the individual testee's social security number or other independent identification, but chosen sequentially; and

D. Maintain confidentiality of all test results and of the identities of all test takers. No dissemination or disclosure of test results shall be made to any third parties, including insurers or prospective insurers and employers or prospective employers, without the written consent of the individual, except: (i) to members of the individual's direct health care-giving team; (ii) to blood, organ, semen, or breast milk banks that have received or will receive blood, an organ, semen, or breast milk from the individual; (iii) to the victim of a sexual assault, pursuant to court order; (iv) pursuant to a court order, where there is a compelling interest in the disclosure of such information which can be served by no other means; and

23. Johnson & Murray, *AIDS Without End*, N.Y. Times, Aug. 18, 1988, (N.Y. Review of Books), at 61, col. 1 (emphasis added) (footnote omitted), citing Booth, *A Frustrating Glimpse of the True AIDS Epidemic*, 258 SCIENCE 747 (1987).

24. REPORT OF THE PRESIDENTIAL COMM'N, *supra* note 4, at 120.

25. AIDS is "increasingly concentrated in disadvantaged groups—poor women, blacks and Hispanics and their infants, the homeless—whence it is bound to spread further." Johnson & Murray, *supra* note 23, at 57, col. 1; *accord* REPORT OF THE PRESIDENTIAL COMM'N, *supra* note 4, at 13-14, 15-16, 104-06.

Given this reality, action should be taken by federal authorities to provide testing and counseling at no cost to those who cannot afford to pay for these services. However, the appropriation of funds cannot be accomplished by administrative regulation and is consequently outside the scope of this analysis. See U.S. CONST. art. I, § 8.

(v) for statistical purposes, such as an agency of the Department of Health and Human Services may require or as may be required by a state or local public health agency; provided that no required report to an agency of the Department or to a state or local public health agency shall disclose the identity of any individual.

2. Because the existence of mandatory testing programs outside of the armed forces, penal institutions, and hospital settings will impede the vital national interest in controlling AIDS while preserving civil liberties, each recipient of combined federal Medicare and Medicaid funds in excess of \$30,000 in the fiscal year 1988 shall annually certify in writing that it has not participated in any mandatory testing program, except for participation in government programs conducted by penal authorities, by the armed forces, or by the Immigration & Naturalization Service, and except for participation in hospital programs for patients undergoing invasive procedures, or serving patients hospitalized for mental disease or mental retardation.

B. *Proposed Regulations Prohibiting Discrimination*

3. Because the pervasive fear of discrimination is a deterrent to testing, no employer or organization engaged in interstate commerce or whose activities affect interstate commerce, and who has fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year, shall discriminate in employment or prospective employment against any individual on the basis that the individual has sought or obtained a test for HIV infection, on the basis of the result of such a test, or on the basis that the individual has been diagnosed as suffering from AIDS or an AIDS-related condition; unless it can be shown that the individual is incapable of performing the employment, or because the nature of the work poses a medically unacceptable risk to others, as determined under guidelines to be promulgated by the Secretary on the basis of empirical evidence.

4. These regulations shall not apply to any religious organization²⁶ which is exempt from federal income taxes under the Internal Revenue Code, or to any state agency or unit of state government.²⁷

5. Each violation of these regulations shall be punished by a fine of not more than \$1,000, or by imprisonment for not more than one year, or both, pursuant to 42 U.S.C. section 271.

IV. PROBABLE CHALLENGES TO THE PROPOSED REGULATIONS

What legal arguments might be advanced against the proposed regulations? Could the regulations survive court challenges?

Any Secretary promulgating the voluntary testing and nondiscrimination regulations described above would have to expect serious legal challenges from the hospital industry and from employers on a number of legal grounds. However, on the merits the challenges should fail.

26. In *NLRB v. Catholic Bishop of Chicago*, 440 U.S. 490 (1979), the Supreme Court held that where the application of a regulatory scheme to religious organizations would raise "serious First Amendment questions," the statute would not be interpreted to authorize such regulation unless Congress "clearly express[ed]" the "affirmative intention" that religious organizations be covered. *Id.* at 504.

Given the close relationship between the history of the AIDS epidemic and the gay community in the United States, and the condemnation of homosexual acts and/or status by many religious groups, constitutional conflict resulting from any attempt to prevent discrimination against HIV testees by religious employers would seem to be inevitable. Such conflict would likely be held to raise "serious First Amendment questions." See generally *McClure v. Salvation Army*, 460 F.2d 553 (5th Cir. 1972) (religious organizations exempt from certain sex discrimination actions under Title VII); Laycock, *Towards a General Theory of the Religion Clauses: The Case of Church Labor Relations and the Right to Church Autonomy*, 81 COLUM. L. REV. 1373 (1981). Accordingly, regulation would not be held to be authorized under the doctrine of *Catholic Bishop* absent an affirmative Congressional intention that religious organizations be regulated. As the discussion in Part IV-D *infra* inferentially makes clear, no such affirmative intention can be discerned here.

27. See *infra* notes 30-43 and accompanying text.

One observation is warranted prior to discussion of the merits: providing that public health regulation does not substantially impair fundamental rights or otherwise trigger heightened constitutional scrutiny, any judicial review of such regulation under existing law is likely to be highly deferential, regardless of the specifics of the measures at issue:

Judges are lawyers by training—they are not doctors or epidemiologists. They will, therefore, be reluctant to second-guess the public health professionals who impose a public health regulation or requirement. From a legal perspective, the officials charged with making the regulations will be given great deference by the courts and judges will not generally substitute their views or opinions for those of appropriate government officials.²⁸

A. *Argument That Regulations Exceed Statutory Authority*

The first legal argument against the voluntary testing regulations might be that they are outside the scope of the statutory authority.

An argument against the regulations could be premised on 42 U.S.C. section 264(c)²⁹ which provides:

Except as provided in subsection (d) of this section, regulations prescribed under this section, insofar as they provide for the apprehension, detention, *examination*, or conditional release of individuals, shall be applicable only to individuals coming into a State or possession from a foreign country or a possession.³⁰

It might be argued based on subsection (c) that the proposed regulations “provide for . . . examination . . . of individuals,” and thus are permissible only for individuals entering the United States, rather than for all individuals who wish to be tested, as the regulation contemplates.

This is a plausible interpretation of the statute. However, an argument that the Secretary exceeded his statutory authority by providing for examination of individuals in violation of section 264(c) should not prevail in federal courts. This is so because the Secretary may just as plausibly interpret the statute to serve his or her purposes.

The Secretary would first differentiate between a blood test and a medical examination: one is not the same as the other. Even assuming, however, that the “testing and counseling” of the regulations could be considered to be “examination,” the Secretary’s interpretation would stress that the prohibition of examination occurs in a sequence which prohibits “apprehension, detention, examination, or conditional release of individuals.” The Secretary would argue that the word “examination” does not appear in a vacuum, and that it is obvious from the context that what Congress meant was to prohibit examinations which occurred *in the time sequence implicit in the sentence*—that is, examination after apprehension and detention, but before conditional release. Thus construed, subsection (c) would

28. Gray, *supra* note 9, at 521.

29. 42 U.S.C. § 264(c) (1982).

30. 42 U.S.C. § 264(c) (emphasis added). Subsection (d) of § 264 provides authority for apprehension and examination of persons reasonably believed to be infected, 42 U.S.C. § 264(d) (1982).

prohibit only *compulsory* examination, and would not restrain a regulation allowing for voluntary examination of individuals.

This interpretation should be upheld by the courts. The Supreme Court has repeatedly and unequivocally held that if a "statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute [A] court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency."³¹

[T]he agency's interpretation of a statute the agency is charged with administering is entitled to considerable deference and it need not be the only permissible construction that the agency could have adopted '[T]he interpretation of a complex statute . . . by the administrative officer charged with the responsibility of administering it, . . . if reasonable, is not to be rejected by a court merely because another interpretation may also be reasonable.'³²

Thus, an attack on the regulations promulgated under section 264 on the theory that they are in excess of the statutory authority should not succeed.

B. *Arguments Based on Other Statutes*

Another probable basis for challenges to the provision of the draft regulations requiring Medicare fund recipients to provide HIV testing is the Medicare statute. 42 U.S.C. section 1395,³³ part of the Medicare scheme, provides:

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . or to exercise any supervision or control over the administration or operation of any such institution, agency or person.³⁴

Moreover, under the Hill-Burton Act,³⁵ the federal government funds hospital construction, and many hospitals are recipients of Hill-Burton funds. That act has a provision—42 U.S.C. section 291m³⁶—which is operatively identical to section 1395.

Any challenge to the proposed voluntary testing regulations, which as seen above would require Medicare fund recipients to provide AIDS testing, would undoubtedly invoke section 1395, and likely invoke section 291m as well, asserting that the regulations violated Congress's clearly expressed intent that the receipt of federal funds not be used to control hospital operations.

This is a substantial argument from a policy standpoint. However, it has a

31. *Young v. Community Nutrition Inst.*, 476 U.S. 974, 980 (1986) (quoting *Chevron U.S.A., Inc. v. National Resources Defense Council*, 467 U.S. 837, 843–44 (1984)).

32. *Department of Social Serv. v. Bowen*, 804 F.2d 1035, 1038 (8th Cir. 1986) (quoting *Health Care Serv. Corp. v. Califano*, 601 F.2d 934, 935–36 (7th Cir. 1979) (per curiam)). *Accord* *Chevron U.S.A.*, 467 U.S. at 843 n.11 ("The court need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction.").

33. 42 U.S.C. § 1395 (1982).

34. *Id.*

35. 42 U.S.C. §§ 291–291o-1 (1982 & Supp. IV 1986).

36. 42 U.S.C. § 291m (1982).

single, rather technical, yet entirely conclusive answer: that nothing "*in this subchapter*" (i.e., in the Medicare or Hill-Burton Acts) can be used to control hospital operation. In this instance, the source of the control is section 264, part of the communicable disease statute.³⁷ And Congress broadly empowered the Secretary to make regulations in this area, without restraint. If Congress had intended section 291m or section 1395 to restrict federal public health authority under section 264 in any way, it would have said so.

C. Due Process Arguments

A further argument against the voluntary testing and counseling regulations as applied to hospitals might be that the regulations impair the hospitals' contractual rights by adding conditions to which the hospitals did not assent at the time they entered into their arrangements with the government, in violation of the due process clause of the fifth amendment. A particular target of such an attack might be the prohibition on participation in mandatory testing programs.

Similar arguments have been rejected by the courts. The Seventh Circuit has stated in a health care context: "[T]here is case law arising out of litigation engendered by the vast growth of governmental regulatory activity in the 1930s and thereafter, which provides precedents strongly supporting *the government's right, when undertaking a regulatory scheme, to alter the expectations and obligations of private parties.*"³⁸ The Tenth Circuit has concurred: "If the regulations are rationally related to the statute and in compliance with the Administrative Procedure Act, the fact that they upset the expectations of the parties does not condemn them."³⁹

These cases might be distinguished on the basis that they addressed situations in which the statute under which the funding program was administered was re-interpreted by the agency to impose additional obligations on the private party, whereas in this case the additional obligations arise from an interpretation of a separate statute, section 264. However, it is significant that section 264 was in place before the Medicare or Hill-Burton Acts, and it can be persuasively argued that the private parties made their arrangements with the government subject to all then-extant federal statutory law, and, therefore, the same principles should apply and the government should not be constrained.

D. Arguments Based on Federalism

It might be argued in a challenge to the regulations that they would be invalid as unduly invasive of matters left traditionally to state regulation.

The leading case in the area is *Bowen v. American Hospital Association*.⁴⁰

37. 42 U.S.C. § 264 (1982).

38. *American Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 183 (7th Cir. 1983) (emphasis added) (holding that 1979 regulations adding conditions to which hospitals did not assent at the time they entered into their agreements with the government under the Hill-Burton Act are not violative of due process guarantees).

39. *Wyoming Hosp. Ass'n v. Harris*, 727 F.2d 936, 941 (10th Cir. 1984) (holding that new regulations which governed uncompensated care obligations of hospitals receiving federal funds and which changed the conditions to which hospitals originally assented at the time they received the funds did not violate the hospitals' due process rights).

40. 476 U.S. 610 (1986).

There, the Supreme Court struck down rules governing the treatment of handicapped infants (the "Baby Doe" regulations) issued by the Secretary of Health and Human Services under the auspices of section 504 of the Rehabilitation Act.⁴¹

The *Bowen* Court had two concerns: First, is there an extension of federal regulation into what was previously an area of exclusive state prerogatives? Second, if so, is adequate evidentiary justification offered for regulations which significantly alter the federal-state balance?

1. *The Extent of Interference*

The Supreme Court observed in *Bowen*: "Important principles of federalism are implicated by any 'federal program that compels state agencies . . . to function as bureaucratic puppets of the Federal Government.'"⁴²

The rules at issue in *Bowen* "command[ed] state agencies to require . . . reports, regardless of the state agencies' own reporting requirements," and "command[ed] state agencies to utilize their 'full authority' to 'prevent instances of unlawful medical neglect of handicapped infants' . . . The rules effectively [made] medical neglect of handicapped newborns a state investigative priority, possibly forcing state agencies to shift scarce resources away from other enforcement activities." The rules compelled state agencies to handle complaints and even mandated that state agencies file lawsuits in certain instances.⁴³ In short, the rules directed state agencies to act as "field offices of the HHS [Health and Human Services] bureaucracy."⁴⁴

In the case of the proposed AIDS regulations, no such intrusion is threatened. These regulations do not require the states to monitor compliance by hospitals or medical offices, to prioritize AIDS discrimination as an investigative target, to handle complaints from any person or institution, or to file lawsuits. These regulations do not affirmatively compel the states to do anything. The states will remain free to regulate consistent with federal regulations. Thus, a state might provide a civil damages remedy for breach of privacy in connection with HIV test results, or criminalize discrimination against persons with AIDS, or even continue without state regulation.

Bowen is a plurality decision. Four Justices joined the Court's opinion, Chief Justice Burger concurred in the judgment, then-Associate Justice Rehnquist took no part in the case, and three Justices dissented. However, *Bowen's* significance as precedent for the analysis herein is not undermined by that fact.

This Article argues that under the *Bowen* standard, the proposed HIV-related regulations should be upheld. The *Bowen* plurality struck down the "Baby Doe" regulations because the Secretary failed to set forth an adequate evidentiary basis for those regulations. "The administrative record does not contain intervention into a historically state-administered decisional process . . ." *Id.* at 645. Two of the three dissenters in *Bowen* argued that in the case of the Baby Doe regulations, the evidentiary standards had indeed been met: "[T]he plurality's determination that the regulations were inadequately supported and explained as a matter of administrative law does not withstand examination of the Secretary's discussion of the underlying problem and of the contours of the regulations themselves." *Id.* at 663 (White, J., joined by Brennan, J.). These dissenters were quite willing to allow federal intervention into a historically state-administered decisional process upon a proper showing. The conflict between the plurality and the dissent concerned whether the undisputed legal standard had been met in that case. Thus, a clear majority of the Court explicitly or implicitly agreed that, upon a proper evidentiary showing and acting under sufficiently broad statutory authority, federal administrative agencies may regulate in an area previously thought to be primarily a field of state regulation.

41. 29 U.S.C. § 794 (1982).

42. 476 U.S. at 642 (quoting *FERC v. Mississippi*, 456 U.S. 742, 783 (1982)).

43. *Id.* at 639 (citations omitted).

44. *Id.* at 642.

This is not a "federal program that compels state agencies . . . to function as bureaucratic puppets of the Federal Government."⁴⁵ There could be no fear that a state might lose federal funding "for failing to carry out the Secretary's mission with sufficient zeal"⁴⁶ because the states would not be charged with carrying out that federal mission.

Moreover, the intervention at issue in *Bowen* was into an area "traditionally left by state law to concerned parents and the attending physicians or, in exceptional cases, to state agencies charged with protecting the welfare of the infant."⁴⁷ There had been no prior involvement by the federal government into this "historically state-administered decisional process."⁴⁸ "Prior to the regulatory activity culminating in the Final Rules, the [f]ederal [g]overnment was not a participant in the process of making treatment decisions for newborn infants."⁴⁹ The same is clearly not true of communicable diseases. While it is indisputable that "[t]raditionally, responsibility for the control of epidemics has rested with state and local governments,"⁵⁰ Congress has ordained a leading role for the federal government in the control of communicable diseases. For example, the Senate Report amending the Public Health Service Act⁵¹ declares:

[E]xperience has taught time after time [that] . . . control of communicable disease is not and should not be solely the responsibility of State and local governments. They cannot do the job alone and *communicable disease does not recognize State boundaries*.⁵²

Regulation of communicable diseases has long been a federal concern. As the Office of Legal Counsel of the Department of Justice has recently noted:

[C]ommunicable diseases are the only public health problem to be a subject of federal statutes from the origin of the country to the present. Congress first addressed the control of communicable diseases in 1796, when it authorized the President to direct federal officials to aid in the execution of quarantine and to assist states in the enforcement of their health laws. This law was replaced in 1799 with a more comprehensive scheme Federal statutes relating to communicable diseases, including provisions for data collection and grants to states, persisted through the next century

This venerable statutory policy continues today in updated form. The Secretary of [Health and Human Services] (or the Surgeon General with the approval of the Secretary) *has broad power to promulgate regulations for the control of communicable disease*.⁵³

45. *Id.* at 642 n.29 (quoting *FERC v. Mississippi*, 456 U.S. 742, 783 (1982)).

46. *Id.* at 641.

47. *Id.* at 644 n.33.

48. *Id.* at 645.

49. *Id.* at 627-28.

50. Comment, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191, 201 (1986).

51. S. REP. NO. 330, 99th Cong., 2d Sess. 39 (1975), reprinted in 1976 U.S. CODE CONG. & ADMIN. NEWS 1234, 1272 (emphasis added).

52. *Id.*

53. Office of Legal Counsel, United States Dep't of Justice, Memorandum Re: Application of Section 504 of the Rehabilitation Act to Persons with AIDS 41-42 (June 23, 1986) (emphasis added) (footnotes omitted).

This Justice Department memorandum is notorious for its conclusion that HIV positivity is not a handicap within the meaning of the Rehabilitation Act, and thus discrimination against HIV-positive persons is not prohibited by the Act. Although the memorandum's analysis is misguided and its ultimate conclusion erroneous, the quoted summary of the history of federal regulation is accurate. See Morgenstern, *The Role of the Federal Government in Protecting Citizens from Communicable Diseases*, 47 U. CIN. L. REV. 537, 541 (1978) ("The federal government entered the public health

Thus the proposed regulations on AIDS lack the cardinal features of the regulations struck down in *Bowen*: They do not extend federal regulation into what was previously an area of exclusive state prerogatives, and they do not force state agencies to function as puppets of a federal bureaucracy, nor impose any affirmative obligations on state agencies at all.

2. The Rationale for Regulation

The clear teaching of the Supreme Court in *Bowen* is that even when a set of federal regulations addresses a new area of federal activity, and that activity is one traditionally left to state regulation, in the absence of clear Congressional intent that the agency act in this area, the regulation will nevertheless be upheld where the agency's rationale and justification are adequate.

The need for a *proper evidentiary basis* for agency action is especially acute in this case because Congress has failed to indicate, either in the statute or in the legislative history, that it envisioned federal superintendence of treatment decisions traditionally entrusted to state governance . . . Congress therefore 'will not be deemed to have significantly changed the federal-state balance'—or to have authorized its delegates to do so—'unless otherwise the purpose of the Act would be defeated'. . . . [T]he propriety of the exertion of the authority must be tested by [1] its relation to the purpose of the [statutory] grant and [2] with suitable regard to the principle that whenever the federal power is exerted within what would otherwise be the domain of state power, the justification of the exercise of the federal power must clearly appear. That is, 'it must appear that there are findings, supported by evidence, of the essential facts . . . which would justify [the Secretary's] conclusion.'⁵⁴

Since, as shown above, communicable diseases have traditionally been a subject of federal regulation, it would not be necessary for a court examining a challenge to the proposed regulations here to reach even the latter part of the *Bowen* analysis.

However, even assuming that the instant regulations interfere as drastically with a historically state-administered decisional process as did the Baby Doe regulations, adequate factual justification for the AIDS regulations as proposed would not be difficult to offer. Indeed, the Centers for Disease Control (CDC) of the Department of Health and Human Services has already produced a document which provides substantial scientific justification for the main features of the proposed regulations. That document is *Recommended Additional Guidelines for HIV Antibody Counseling and Testing in the Prevention of HIV Infection and AIDS*.⁵⁵

The regulations posit that there is a need for testing and counseling of persons who may be at risk for AIDS and that every individual should have the choice whether to be tested or not. The *Recommended Additional Guidelines* state:

field in 1796."'). (This Justice Department memorandum has been superseded by *Arline* and overruled by the Justice Department memo of October of 1988. See *Justice Department Opinion Overturns Controversial 1986 Memo on § 504*, 3 AIDS POL'Y & L. (BNA) No. 19, at 1 (Oct. 19, 1988).

54. *Bowen v. American Hosp. Ass'n.*, 476 U.S. 610, 643-45 (1986) (plurality opinion) (citations omitted).

55. CENTERS FOR DISEASE CONTROL, *RECOMMENDED ADDITIONAL GUIDELINES FOR HIV ANTIBODY COUNSELING AND TESTING IN THE PREVENTION OF HIV INFECTION AND AIDS* (Apr. 30, 1987) [hereinafter *RECOMMENDED ADDITIONAL GUIDELINES*]. This material is cited here as illustrative of the fact that an adequate evidentiary basis is readily available. Any regulations should be the subject of hearings and a report with specific findings on the need for such regulations, in accordance with the Administrative Procedure Act.

"In the absence of vaccines or chemoprophylactic drugs, our best hopes for preventing HIV transmission rest on a strategy based on information and education. Counseling persons who are at risk of acquiring HIV infection and offering HIV antibody testing is an important component of that strategy."⁵⁶

The regulations make assurance of confidentiality for all persons who have been tested an important priority. The *Recommended Additional Guidelines* provide:

The ability of health departments, hospitals, and other health-care providers to assure confidentiality of patient information, and the public's confidence in that ability, are crucial to efforts to increase the number of persons requesting or willing to undergo counseling and testing for HIV antibod[ies]. Of equal or even greater importance is the public's perception that persons found to be positive will not experience unfair treatment as the result of being tested.⁵⁷

If confidentiality cannot be assured, procedures allowing anonymity should be available as an option for persons who would otherwise be deterred from being tested.⁵⁸

The proposed regulations also prohibit discrimination against persons with AIDS and HIV-positive persons. The *Recommended Additional Guidelines* state:

Persons with AIDS are known to have received unequal treatment in such areas as employment, school admission, housing, medical services, and insurance coverage. The concept of voluntary testing obviously is dependent upon the perception that persons who allow themselves to be tested will be given protection against unjustified discrimination if they are antibody positive . . . [P]ublic health prevention strategy to encourage HIV testing requires that efforts be made to reduce unequal treatment against persons who are positive.⁵⁹

Thus, substantial factual justification for the proposed regulations would not be difficult to present based on the Centers for Disease Control's *Recommended Additional Guidelines* alone. When taken together with the public health justifications for guarantees of confidentiality and nondiscrimination set forth in the Institute of Medicine/National Academy of Sciences report and the Report of the Presidential Commission, that there is a substantial basis for federal regulation appears inarguable. Accordingly, the regulations would not be held to violate the principles of federalism expressed in *Bowen*.

56. *Id.* at 1.

57. *Id.* at 9.

The Supreme Court spoke to a closely related point in *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), stating that "an important obstacle to preventing the spread of infectious diseases" is "the individual's reluctance to report his or her condition" because of fear of irrational responses by employers. *Id.* at 1130 n.15.

"Without adequate assurances of confidentiality, PWA's [persons with AIDS] may lie about their sexual contacts for fear of persecution, sympathetic physicians may fail to report AIDS cases, and vital information needed by CDC and researchers will be inaccurate or incomplete." Comment, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191, 198 (1986).

58. RECOMMENDED ADDITIONAL GUIDELINES, *supra* note 55, at 14.

59. *Id.* at 13 (footnote omitted).

Other authorities also strongly support the proposition that there is a need for protection against HIV-related discrimination. See, e.g., Blendon & Donelan, *supra* note 7. The authors of the *New England Journal* article examined 53 national and international opinion research surveys on the topic of AIDS. They reported, *inter alia*, that "[o]ne in five [Americans surveyed] say patients with AIDS are 'offenders' who are getting their rightful due; 29 percent say they favor a tattoo for the disease . . . [and] 17 percent say those with AIDS should be treated as those with leprosy were in an earlier era, by being sent to far-off islands." *Id.* at 1023 (footnotes omitted).

On the question of employment discrimination, the *New England Journal* authors report: "one in four respondents [in the United States] says he or she would refuse to work alongside a person with AIDS, and the same proportion believe employers should have the right to fire a person for this reason alone." *Id.*

E. *The Preemption of State Law*

Closely related to the question of federalism under *Bowen* is whether and to what extent the regulations would be held to preempt or displace state regulations under the Supremacy Clause of the federal constitution.⁶⁰

Federal law preempts state law in four basic contexts: (1) where state law is expressly preempted by federal law; (2) where Congress has "occupied the field" of regulation entirely; (3) where there is "actual conflict" between the operation of federal law and state law; and (4) where state law encourages conduct the absence of which is important to the effectiveness of the federal scheme.⁶¹

Plainly, Congress did not intend to occupy exclusively the field of regulation of communicable diseases when it enacted 42 U.S.C. section 264⁶² and related statutes. This is evident from Congress's provision in 42 U.S.C. section 243(c)⁶³ that the Secretary may assist states in their efforts to control health emergencies. Nor can it be denied in the face of the plain language of section 264 that Congress envisioned that the Secretary would regulate directly in the area of communicable diseases.

Thus, the proposed federal regulations would not entirely preempt state regulations aimed at combating AIDS. States would remain free to regulate regarding AIDS. States *could*, for example, pass laws legalizing the retail sale of hypodermic needles, or provide individual damage remedies for victims of discrimination, or provide funds for research. States *could not*, for example, require that the identities of voluntary testees be reported to any state agency, or legalize discriminatory treatment by employers.

According to the Supreme Court:

[S]tate law is nullified to the extent that it actually conflicts with federal law. Such a conflict arises when 'compliance with both federal and state regulations is a physical impossibility,' or when state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress. . . .'

Federal regulations have no less preemptive effect than federal statutes. Where Congress has directed an administrator to exercise his discretion, his judgments are subject to judicial review only to determine whether he has exceeded his statutory authority or acted arbitrarily. When the administrator promulgates regulations intended to pre-empt state law, the court's inquiry is similarly limited. 'If [h]is choice represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, we should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned.'⁶⁴

The proposed regulations represent a reasonable accommodation of conflicting policies, and nothing on the face of section 264 indicates that Congress would not have sanctioned the regulations.

Section 264, giving the Secretary broad powers to make regulations to control

60. U.S. CONST. art. VI, cl. 2.

61. See, e.g., L. TRIBE, AMERICAN CONSTITUTIONAL LAW §§ 6-25 to 6-28 (2d ed. 1988).

62. 42 U.S.C. § 264 (1982).

63. *Id.* § 243(c) (1982).

64. *Fidelity Fed. Savings & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 153-54 (1982) (emphasis added) (citations omitted).

communicable diseases, was last substantively amended in 1944. The legislative history indicates that the 78th Congress intended to empower the Surgeon General (and later, the Secretary) so that he might have the necessary flexibility to combat communicable diseases of the future.

The legislative history shows that although the amendment was designed to "expressly sanction the use of conventional public-health enforcement methods,"⁶⁵ Congress intended to grant the executive branch of government "[t]he basic authority to make regulations to prevent the spread of disease into this country or between the States . . . unencumbered by the confusing limitations found in [prior law]. These limitations have ceased to serve any useful purpose"⁶⁶ The rationale for Congress's delegation is thus apparent. The House Committee candidly and explicitly recognized "*the impossibility of foreseeing what preventive measures may become necessary*" to fight communicable diseases.⁶⁷ Of course, the 78th Congress could not foresee the development of AIDS in the United States some forty years later.

Respecting section 264, it should be concluded that Congress had no actual intent with regard to regulations aimed at combating AIDS and implementing strategies of voluntary confidential testing and nondiscrimination. It simply cannot be stated with confidence that the Congress which passed section 264, had it possessed a modern knowledge about the medical and social effects of AIDS, would have disapproved the proposed regulations. Although it is clear that the enacting Congress had no actual intent with regard to what regulations the Surgeon General or his statutory successor the Secretary might make to address AIDS, Congress did intend to grant the Surgeon General flexible powers to address future problems.

In *Chevron U.S.A., Inc. v. Natural Resources Defense Council*,⁶⁸ the Supreme Court addressed the effect of determining that Congress had no actual intent regarding the type of regulation at issue:

Once [the reviewing court] determined, after its own examination of the legislation, that Congress *did not actually have an intent* regarding the applicability of the bubble concept to the permit program, the question before it was not whether in its view the concept is 'inappropriate' in the general context of a program designed to improve air quality, but whether the Administrator's view that it is appropriate in the context of this particular program is a reasonable one.⁶⁹

65. H.R. REP. NO. 1364, 78th Cong., 2nd Sess., 1944 U.S. CODE CONG. SERV. 1211, 1234.

66. *Id.*

67. *Id.* at 1235 (emphasis added). This recognition admittedly came in a passage of the Committee Report which discussed subsection (d), the quarantine provision. The passage reads: "In view of the possible impact, especially in the post-war period, of other diseases than the venereal, and the impossibility of foreseeing what preventive measures may become necessary, the provisions of this subsection are written broadly enough to apply to any disease listed by the President as quarantinable"

Though the passage refers explicitly only to subsection (d), it demonstrates Congressional awareness of the need for breadth in the scope of permissible regulation to allow for effectiveness in dealing with future emergencies of unknowable dimension and scope. This awareness is clearly reflected in the broad scope of subsection (a), even more so than in the parameters of subsection (d).

68. 467 U.S. 837 (1984).

69. *Id.* at 845 (emphasis added). *Accord* *Lukhard v. Reed*, 107 S. Ct. 1807, 1813 n.3 (1987) ("For the purpose of determining the application of an existing agency-interpreted statute to a point on which 'Congress did not actually have an intent,' . . . we have held that 'a court may not substitute its own construction . . . for a reasonable interpretation made by the administrator of an agency.'").

Thus, where no actual intent of Congress with regard to the particular program can be ascertained, the regulation will be upheld where the agency's determination of appropriateness is reasonable.

In this area, no actual intent of the enacting Congress regarding regulations on AIDS can be discerned, because the statute was last amended long before the AIDS crisis arose. The regulations are reasonable, and should be held by federal courts to preempt or supersede conflicting state or local regulations.

F. *Commerce Clause Arguments*

The ultimate source for federal regulation of public health is the Commerce Clause.⁷⁰ "Responsibility for interstate . . . health questions is delegated to the federal government, which exercises vast power in the field of public health through its power to regulate interstate and foreign commerce"⁷¹

The regulations prohibit discrimination in employment activities affecting interstate commerce, under penalty of federal criminal prosecution. This regulation would reach all businesses of any substantial size—employing over fifteen persons and engaged in an activity affecting commerce—as does Title VI, the Equal Employment Opportunity Act.⁷²

There have been other comparable schemes enacted by Congress and upheld by the Supreme Court; for example, Title II of the 1964 Civil Rights Act, prohibiting racial and religious discrimination in all places of public accommodation which "affect commerce."⁷³ The modern interpretation by the courts of what activities may be reached by federal regulation under the Commerce Clause is extremely broad.⁷⁴ "[I]t has long been settled that Congress' authority under the Commerce Clause extends to intrastate economic activities that affect interstate commerce."⁷⁵ Section 264 is clearly a valid exercise of Congressional power under the Commerce Clause, and, as indicated above, the proposed regulations are within the scope of section 264.

V. AIDS POLICY AND THE ROLE OF REGULATION

AIDS knows no state boundaries. Comprehensive federal regulation guaranteeing anonymity and confidentiality for persons wishing to be tested for the HIV virus, and assuring nondiscrimination in employment for persons suffering from AIDS and HIV-positive persons, may be made by the Secretary under existing law. There is a clear statutory basis for such regulations, which would preempt conflicting state

70. U.S. CONST. art. I, § 8, cl. 3.

71. Morgenstern, *supra* note 53, at 544-45.

72. 42 U.S.C. § 2000e (1982).

73. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 247 (1964); *Katzenbach v. McClung*, 379 U.S. 294, 302 (1964).

In this case the regulations would be primarily justified by public health reasons, and "commercial reasons" would play a secondary, though significant, role. Professor Tribe has noted that despite "views that congressional exercise of the commerce power should be confined to strictly 'commercial' regulation, the Supreme Court has consistently upheld congressional use of 'protective conditions' to combat activities disfavored for largely non-commercial reasons." L. TRIBE, *supra* note 61, §§ 5-7, at 312 (2d ed. 1988).

74. See, e.g., *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 280-83 (1981).

75. *Garcia v. San Antonio Met. Transit Auth.*, 469 U.S. 528, 537 (1985).

laws. The probable legal arguments against the proposed regulations are unpersuasive.

Achieving the public health policy goals of guaranteeing confidentiality and nondiscrimination nationwide for persons with AIDS and HIV-positive individuals can be done through federal regulation under existing law, as demonstrated above, or through new federal legislation, as has been suggested by others, or through some combination of the two. Each avenue, legislation and regulation, has its limits and its advantages.

As the failure of the 100th Congress to approve legislation protecting the confidentiality of HIV testees⁷⁶ dramatically demonstrates, AIDS unfortunately remains a political issue. The circumstances of political life have made it impossible to pass any comprehensive federal AIDS legislation in a reasonably swift fashion, despite the calls for legislative action by such impartial bodies as the National Academy of Sciences.

Regulation under section 264 may have one major remedial limitation: it is arguable that no private right of action on behalf of those who are the victims of discrimination or breach of confidentiality can be created under this section.⁷⁷ Regulation has its advantages as well. Regulation depoliticizes AIDS; it removes the question from the political context, and places it in a public health context. It makes swift and effective action possible, and it unequivocally sets national policy in a coordinated fashion. An enlightened federal policy committed to vigorously combating AIDS on the medical front and to the decent and humane treatment of AIDS victims consistent with civil rights would involve a program of legislation supplemented by regulation under section 264.

One federal court has observed: "Under . . . the Public Health Service Act's authorization for regulations to control communicable diseases, 42 U.S.C. section 264 . . . the Secretary has *both the authority and the heavy responsibility* to act to protect the nation's health"⁷⁸

The authority to enact regulations under section 264 to combat the further transmission of AIDS had been on the statute books for almost four decades when the AIDS epidemic emerged as a public health issue in 1983.⁷⁹ Five years later, the epidemic has worsened. The regulatory authority remains unexercised. The "heavy responsibility" is still unmet.

Shortly after Congress last amended section 264, Albert Camus wrote: "Everybody knows that pestilences have a way of recurring in the world; yet somehow

76. See *supra* note 8 for a discussion of the defeat of AIDS confidentiality legislation in the 100th Congress in October 1988.

77. Generally, but not invariably, the fact that a federal statute provides a criminal penalty for violation will be held to preclude a private right of action by affected individuals. See *Cort v. Ash*, 422 U.S. 66 (1975). Cf. *Allen v. State Bd. of Elections*, 393 U.S. 544 (1969).

78. *Public Citizen v. Heckler*, 602 F. Supp. 611, 613 (D.D.C. 1985) (emphasis added) (holding that under section 264 as well as under 21 U.S.C. § 342, the Secretary of Health and Human Services was obligated to act on a petition seeking to ban all domestic sales of raw milk and raw milk products).

79. By 1983 an assistant secretary of health had labeled AIDS as the Public Health Service's "number one priority." S. PANEM, *THE AIDS BUREAUCRACY* 15, 31 (1988).

we find it hard to believe in ones that crash down on our heads from a blue sky.”⁸⁰ It is time for the federal government to start believing in AIDS, and time for it to exercise, in a responsible and humane fashion, the authority which Congress has provided.

80. A. CAMUS, *THE PLAGUE* 34 (S. Gilbert trans. 1948).